HB3190 FA1 NewtonCa-TJ
3/12/2024 8:58:34 am

FLOOR AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB3190
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Carl Newton

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

FLOOR SUBSTITUTE
FOR
HOUSE BILL NO. 3190 By: Newton

FLOOR SUBSTITUTE

An Act relating to health insurance; creating the Ensuring Transparency in Prior Authorization Act; defining terms; requiring disclosure and review of prior authorization; requiring certain personnel make adverse determinations; requiring consultation prior to adverse determination; requiring certain criteria for reviewing physicians; establishing certain obligations for utilization review entity in certain circumstances; prohibiting certain retrospective denial; providing for length of prior authorization in certain circumstances; providing continuity of care; providing for severability; providing for noncodification; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Adverse determination" means a determinization by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated as defined by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition that lasts one (1) year or more and requires ongoing medical attention or limits activities of daily living or both;

3. "Clinical criteria" means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health care services;

4. "Emergency health care services", with respect to an emergency medical condition as defined in 42 U.S.C.A., Section 300gg-111, means:

a. a medical screening examination, as required under Section 1867 of the Social Security Act, 42 U.S.C.,

Section 1395dd, or as would be required under such section if such section applied to an independent, freestanding emergency department, that is within the capability of the emergency department, of a hospital or of an independent, freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

b. within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department, as applicable, such further medical examination and treatment as are required under Section 1395dd of the Social Security Act, or as would be required under such section if such section applied to an independent, freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished, as defined by 42 U.S.C.A., Section 300gg-111;

5. "Emergency Medical Treatment and Active Labor Act" or "EMTALA" means Section 1867 of the Social Security Act and associated regulations;

6. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents, as defined by Section 6592.1 of Title 36 of the Oklahoma Statutes;

7. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health care services" means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition, as defined by Section 1-1708.1C.2 of Title 63 of the Oklahoma Statutes.

The term also includes the provision of mental health and substance use disorder services, as defined by Section 6060.10 of Title 36 of the Oklahoma Statutes, and the provision of durable medical equipment. The term does not include the provision, administration, or prescription of pharmaceutical products or services;

9. "Licensed mental health professional" means:

a. a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,

b. a psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry,

c. a physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act,

d. a clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists,

e. a professional counselor licensed pursuant to the Licensed Professional Counselors Act,

f. a person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act,

g. a licensed marital and family therapist as defined in the Marital and Family Therapist Licensure Act,

h. a licensed behavioral practitioner as defined in the Licensed Behavioral Practitioner Act,

i. an advanced practice nurse as defined in the Oklahoma Nursing Practice Act,

j. a physician assistant who is licensed in good standing in this state, or

k. a licensed alcohol and drug counselor/mental health (LADC/MH) as defined in the Licensed Alcohol and Drug Counselors Act;

10. "Medically necessary" means services or supplies provided by a health care provider that are:

a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,

b. in accordance with standards of good medical practice,

c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and

d. the most appropriate supply or level of service that can safely be provided to the enrollee as defined by Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or through the United States Postal Service or common carrier;

12. "Physician" means an allopathic or osteopathic physician licensed by the State of Oklahoma or another state to practice medicine;

13. "Prior authorization" means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. The term shall include "authorization", "pre-certification", and any other term that would be a reliable determination by a health benefit plan.

The term shall not be construed to include or refer to such processes as they may pertain to pharmaceutical services;

14. "Urgent health care service" means a health care service with respect to which the application of the time periods for making an urgent care determination, which, in the opinion of a physician with knowledge of the enrollee's medical condition:

a. could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or

b. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

15. "Utilization review entity" means an individual or entity that performs prior authorization for a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes, but shall not include any health plan offered by a contracted entity defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program or other insurance subject to the Long Term Care Insurance Act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its website to enrollees and health care providers. Prior authorization requirements shall be described in detail but also in easily understandable language.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement or restriction is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall provide contracted health care providers credentialed to perform the service, or enrollees who have a chronic condition and are already receiving the service for which the prior authorization changes will impact, notice of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall ensure that all adverse determinations are made by a physician or licensed mental health professional. The physician or licensed mental health professional shall:

1. Possess a current and valid nonrestricted license in any United States jurisdiction;

2. Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being requested; and

3. Make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of reviewing health care services to enrollees of Oklahoma. All such medical directors must be physicians licensed in any United States jurisdiction.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall ensure that all appeals are reviewed by a physician or licensed mental health professional. The physician or licensed mental health professional shall:

1. Possess a current and valid unrestricted license in any United States jurisdiction;

2. Be of the same or similar specialty as a physician or licensed mental health professional who typically manages the

medical condition or disease, which means that the physician either maintains board certification for the same or similar specialty as the medical condition in question or whose training and experience:

a. includes treating the condition,

b. includes treating complications that may result from the service or procedure, and

c. is sufficient for the physician or licensed mental health professional to determine if the service or procedure is medically necessary or clinically appropriate,

except for appeals coming from a licensed mental health professional, which may be conducted by another licensed mental health professional as opposed to a physician;

3. Not have been directly involved in making the adverse determination;

4. Not have any financial interest in the outcome of the appeal; and

5. Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of those medical records which are pertinent and relevant to the active condition provided to the utilization review entity by the enrollee's health care provider, or a health care facility, and any pertinent medical literature provided to the utilization review entity by the health care provider.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For plan years beginning on or after January 1, 2027, a health benefit plan must implement and maintain a Prior Authorization Application Programming Interface (API), as described in 45 C.F.R. Part 156.

B. By July 1, 2027, health care providers must have electronic health records or practice management systems that are compatible with the API.

C. As of the effective date of this act, a utilization review entity must provide health care providers with the following opportunities for communication during the prior authorization process:

1. Make staff available at least eight (8) hours a day during normal business hours for inbound telephone calls regarding prior authorization issues;

2. Allow staff to receive inbound communication regarding prior authorization issues after normal business hours; and

3. Provide a treating provider with the opportunity to discuss a prior authorization denial with an appropriate reviewer.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a utilization review entity requires prior authorization of a health care service, the utilization review entity must make a prior authorization or adverse determination and notify the enrollee and the enrollee's health care provider of the prior authorization or adverse determination in accordance with the time frames set forth below:

1. For purposes of approving prior authorization for urgent health care services, within seventy-two (72) hours of obtaining all necessary information to make the prior authorization or adverse determination; or

2. For purposes of approving prior authorization for non-urgent health care services, within seven (7) days of obtaining all necessary information to make the prior authorization or adverse determination.

For purposes of this section, "necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

B. For those health care providers that submit all necessary information through the utilization review entity's authorized prior authorization system, health care services are deemed authorized if a utilization review entity fails to comply with the deadlines set forth in this section.

C. In the notification to the health care provider that a prior authorization has been approved, the utilization review entity shall

include in such notification the duration of the prior authorization or the date by which the prior authorization will expire.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A utilization review entity shall not require prior authorization for pre-hospital transportation, for the provision of emergency health care services, or for transfers between facilities as required by the Emergency Medical Treatment and Active Labor Act.

B. A utilization review entity shall allow an enrollee and the enrollee's health care provider a minimum of twenty-four (24) hours following an emergency admission or provision of emergency health care services for the enrollee or health care provider to notify the utilization review entity of the admission or provision of health care services. If the admission or health care service occurs on a holiday or weekend, a utilization review entity cannot require notification until the next business day after the admission or provision of the health care services.

C. A utilization review entity shall cover emergency health care services in accordance with the requirements of Section 6907 of Title 36 of the Oklahoma Statutes.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan may not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five (45) business days from the date the health care provider received the prior authorization unless the enrollee was no longer eligible for care on the day care was provided.

B. A health benefit plan must pay a contracted health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization, unless:

1. The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;

2. The health care service was no longer a covered benefit on the day it was provided;

3. The health care provider was no longer contracted with the patient's health benefit plan on the date the care was provided;

4. The health care provider failed to meet the utilization review entity's timely filing requirements; or

5. The patient was no longer eligible for health care coverage on the day the care was provided.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a prior authorization is required for a health care service, other than for inpatient care, for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least six (6) months from the date the health care provider receives the prior authorization approval, unless clinical criteria changes and notice of the change in clinical criteria is provided as stipulated in this act.

B. If a prior authorization is required for inpatient acute care for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

1. If an enrollee requires inpatient care beyond the length of stay that was previously approved by the utilization review entity, then the utilization review entity shall evaluate any prior authorization requests for the continuation of inpatient care according to the provisions of this act. A utilization review entity shall not use any stricter criteria to determine medical necessity and appropriateness of the continuation of inpatient care as the utilization review entity used to evaluate the initial request for authorization of inpatient care. A utilization review entity shall review any relevant and pertinent literature or data provided by the health care provider to determine the medical necessity and appropriateness of the requested length of stay and/or

continuation of inpatient care. A prior authorization for the continuation of inpatient care shall remain valid for a maximum of fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

2. If a utilization review entity fails to respond to a health care provider's timely prior authorization request for the continuation of inpatient acute care before the termination of the previously approved length of stay, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient care provided until the utilization review entity issues its determination on the prior authorization request.

For the purposes of this section, a timely request for continuation of inpatient care means a request that is submitted at least seventy-two (72) hours prior to the termination of the previously approved prior authorization and includes all necessary information for the utilization review entity to make a determination.

3. If a utilization review entity issues an adverse determination to a health care provider's prior authorization request for continuation of inpatient acute care and the health care provider appeals the adverse determination according to the provisions of this act, then the health benefit plan shall continue

to compensate the health care provider at the contracted rate for inpatient care provided until the appeal has been finalized.

C. This section does not require a health benefit plan to cover care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial sixty (60) days of an enrollee's coverage under a new health plan.

B. During the time period described in subsection A of this section, a utilization review entity may perform its own review to grant a prior authorization or make an adverse determination.

C. A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company for the initial sixty (60) days of an enrollee's coverage under the new

product unless the service is no longer a covered service under the new product.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared to be severable.

SECTION 13. This act shall become effective January 1, 2025.

59-2-10728 TJ 03/11/24